Antibiotics prescribed before test*	Result of antigen detection test	Antibiotics prescribed after test result known	No of patients (% of total)	Results on culture†	
				Positive	Negative
Yes	Positive	Yes	203 (15)	183	20
Yes	Negative	Yes	83 (6)	4	79
Yes	Negative	No	81 (6)	4	77
No	Positive	Yes	159 (12)	144	15
No	Positive	No	1 (>1)	1	0
No	Negative	No	800 (60)	54	746
Total			1327 (100)	390	937

*On basis of clinical assessment.

†Values are numbers of patients.

of the test they decided whether to prescribe antibiotics or not. A throat swab was sent to the streptococcus laboratory in Copenhagen for culture.

A total of 1389 patients were included initially; 62 were subsequently excluded because their data were incomplete. Of the remaining 1327 patients, 390 (29%) had group A streptococci on culture. The overall sensitivity and specificity of the tests compared with culture were 84% and 94%, respectively. The table shows the distribution of patients according to the result of the antigen detection test and the general practitioner's decision whether to prescribe antibiotic before and after the test results. The table also shows the numbers of patients positive and negative for group A streptococci on culture. The use of antigen detection tests led to an increase in the prescribing rate for patients with positive results on culture (from 49% (191/390) to 85% (331/390)) but to a decrease in the prescribing rate for those with negative results (from 19% (176/937) to 12% (114/937)). Overall, the use of the tests led to an increase in the prescribing rate of antibiotics from 28% (307/1327) to 34% (440/1327) of patients with a sore throat ($P < 0.001$, McNemar's test). In 164 patients the result of the antigen detection test was negative and in disagreement with the pretest decision. Antibiotics were prescribed to 83 of them (51%), and culture revealed infection with group A streptococci in only four (5%). Of the remaining 81 patients, only four (5%) had group A streptococci on culture.

Thus, in our study the use of antigen detection tests led to a substantial increase in the prescribing of antibiotics to patients infected with group A streptococci but to only a modest decrease in prescribing to patients without such infection. Redd *et al* reported similar findings, but the sensitivity of their test was low (63%).³ In a study performed in a university family practice model office the use of an antigen detection test with a high sensitivity (82%) led to a more rational prescribing pattern and an overall reduction in the physicians' use of antibiotics.⁴ The discrepancy between the impact of using tests with comparable sensitivities in the university model office and in the general practice setting could be due to differences in the doctor-patient relationship. It may be more difficult for the general practitioners to withstand a demand for antibiotic treatment, thus leading them to ignore inappropriately a negative test result. The use of antigen detection tests could lead to a greater improvement in the quality of care in general practice if negative test results were adhered to as strictly as are positive test results.

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Should doctors charge doctors for medical services?

Tradition of not charging should remain

EDITOR,—Anthony Kenney suggests that doctors should continue to avoid charging other doctors and their immediate families unless asked by the patient to do so,¹ thus reinforcing the representative body's reminder that we should not bill each other.² He goes on to say, however, that if this became standard practice insurance companies might have to adjust their premiums accordingly. Unfortunately, British United Provident Association (BUPA), for one, has already done so, and its initially generous discounts in the BMA scheme have been steadily eroded over the years simply because doctors have continued to charge each other. It is not true to say that the Inland Revenue will not allow companies to finance gifts for the providing doctor; BUPA will do so under the BMA scheme when no charge is made unless the patient is already claiming tax relief on his or her premiums or has only the limited cover of the hospital scheme.

It would be a pity to allow ourselves to be influenced by the increasing pressure to change tradition. We might reach the situation in which I found myself when consulting a colleague in central London who suggested that if his fees were an embarrassment to me he would happily continue to see me—in his NHS clinic on the other side of London.

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Doctors should continue to choose NHS care

EDITOR,—The NHS is changing fast, but anyone reading Anthony Kenney's editorial on whether doctors should charge doctors for medical services would think that it had disappeared completely.¹ For most doctors, working in and committed to the NHS, the important issue is not how to negotiate a private arrangement but whether, when, and how to access health care—NHS health care—when they need it.

It can be difficult: 27% of general practitioners in a recent survey had borderline depression or were definitely likely to be depressed.² It takes

courage for a doctor who is exhausted, drained, or depressed to acknowledge that he or she needs help. In other circumstances, for a more physical complaint, a fast track for medical colleagues may be offered. This, as a recent personal view showed, can be risky: "Doctors and their wives should be treated as ordinary patients"; "they should not be involved in diagnosis and clinical decision making."³

There will inevitably be times in doctors' lives when they need to be patients. They have the right, as any citizen does, to NHS care. Most doctors, like most citizens, wish to ignore the propaganda of the private medical insurance companies and exercise that right.

If the general public is given the impression that doctors automatically choose the private route or that the usual system is not good enough for them, what message does that give about the system? It is indeed tempting to short circuit the system, to ask for special privileges. If, however, everyone else in the outpatient waiting room is waiting an hour and half to be seen why shouldn't I share that experience? Why should I, or the consultant who eventually sees me and apologises for not having seen me ahead of my turn, assume that the time of the people in front of me is less valuable than mine? Why should any of us have been waiting an hour and a half?

The more it is assumed that ordinary NHS care (which is often extraordinary) is not good enough for doctors the more we are removed from the opportunity to benefit from, and to fight for, our health service.

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Future of purchasing

Health authorities will have little power to implement strategies

EDITOR,—I cannot share Chris Ham's optimism that "reports of the death of health authorities may be premature."¹ Following the announcement by the secretary of state for health of the extension of the general practice fundholding scheme and the latest letter and accompanying booklet on the development of NHS purchasing from the NHS Executive,² I am concerned that the death of health authorities seems fairly imminent.

The extension of the general practice fundholding scheme in terms of both the number of general practices that can elect to become fundholders and the type of fundholding will reduce the role of health authorities as purchasers of health care and therefore their leverage with providers. Ham argues that this will mean that health authorities will be less bothered by purchasing and will be able to place greater emphasis on strategic commissioning. This view is shared by the government, which envisages three roles for the new single health authorities replacing district health authorities and family health services authorities: strategy, monitoring, and support. In this new phase of the reforms fundholders become "increasingly important as purchasers in their own right" while health authorities will be responsible for "implementing national health policy."³

What is the point of health authorities having responsibility for strategy if their power to purchase services is severely curtailed? In this vision health authorities can carry on producing